

LEVERAGE FOR SYSTEMS CHANGE

A Perspective on the 1995
Department of Mental Health
Home and Community Based Waiver

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L i t t l e B o o k P u b l i c a t i o n o f
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LEVERAGE FOR SYSTEMS CHANGE

Introduction

The Arcadia Institute is pleased to offer this timely publication as part of its Little Book Series on perspectives on policy affecting persons with disabilities. This document is one part of a statewide program to provide information on the most recent waiver request by the State of Michigan for that part of its Medical Assistance Program, commonly known as the Home and Community-Based or (HAB) Waiver.

The other two parts were: (1) three periodic Information Updates on the Waiver and related systems changes, and (2) three Information forums which were held in Oakland (November 27, 1995), Kalamazoo (December 4, 1995), and Bay (December 6, 1995) counties. This document represents the completion of that information program.

However, the Push for Community Project extends beyond providing information on the HAB Waiver and its related systems issues. It will have a life for as long as it is necessary to fight for two basic objectives: (1) the right of persons with disabilities to make their own decisions and receive the support they need to do so, and (2) the obligation that communities have to include all people.

These twin goals of building inclusive communities and supporting individuals to make personal decisions are the first two components of the Mission Statement of The Arcadia Institute. The third thrust is that of supporting the entrepreneurial spirit necessary to achieve significant systems changes. The work on the current HAB Waiver and the broader policy implications represent such a change effort.

The basic tenet of this document is that the work on the HAB Waiver provides the leverage we need to use Medicaid funding to serve people with disabilities. The basic provisions in the Waiver for Person-Centered Planning have already become statutory requirements in the newly revised Mental Health Code. The Director of the Department of Mental Health has made a public commitment to adhere to these principles in the administration of federal Medicaid dollars in the future. He has also initiated a process to change the Administrative Rules and Department Guidelines for Mental Health programs so that they will be aligned with the key provisions in the new HAB Waiver.

As much as anything, this is a story about vision, a vision of what makes sense for, and to, persons with disabilities and their families. There is certainly no better exponent of that vision than the author, Dohn Hoyle. I am reminded of an answer William Faulkner once gave in an interview for the Paris Review. In response to the question, "How did The Sound and the Fury begin?", Faulkner said it began with a mental picture "of the muddy seat of a little girl's drawers in a pear tree, where she could see through a window where her grandmother's funeral was taking place and report what was happening to her brothers on the ground below."

Our vision of persons with disabilities making choices about their own lives, participating fully in community life, making a difference through their contributions is as simple, on one level, as Faulkner's glimpse of that little girl. On another level, we have all had to learn that something so simple and so clear always involves an incredible amount of work.

We want to extend our appreciation to Dohn and Sylvia Kloc, who has been living through the impact of Medicaid reform with her son Steven, to the members of the Howell Group, particularly those who have spent innumerable hours in weekly meetings on the Waiver (Patti Dudek, Sally Harrison, Jim Dehm, Rebecca Shuman, and Beth Durkee) and to the Department of Mental Health staff (especially Bill Harrison, Judy Webb, and Mike Head) and Jim Haveman and Bill Allen, Director and Deputy Director respectively.

It is our hope that the policy changes made so far will become the pattern for restructuring Mental Health services in Michigan. It is also our hope the spirit of risk-taking in uncharted waters that has pushed this effort so far will continue to move us all to continually analyze and improve our work.

George T. Martin, President The
Arcadia Institute

THE HOME AND COMMUNITY BASED WAIVER

HISTORY:

Medicaid was established by Title XIX of the Social Security Act of 1965 to assist qualified low income individuals with health care coverage. It is a jointly funded program, with the Federal government paying for a share of the cost of covering all the eligible people in the state. Section 1915(c) of Title XIX was enacted in 1981 to allow the federal government through the Secretary of Health and Human Services to waive certain requirements of Medicaid which enables states to provide optional services, such as home and community based service, habilitation services, etc. using Medicaid dollars.

The intent of Congress in enacting Section 1915(c) was to grant states greater latitude and flexibility in managing Medicaid-reimbursable long-term care services. Since the establishment of the Medicaid program, such long-term care services had typically been provided in a hospital, nursing home, or other such institutional setting. Historically, one could view Section 1915(c) as an accommodation to those who had been calling for "Medicaid Reform", aimed at leveling of the playing field and an attempt to remove perceived Medicaid bias towards institutions. Another legitimate view is that enactment of this Section was a recognition of what was already occurring in the states in the way of de-emphasizing institutional services and merely permitted reprogramming of Medicaid dollars to "community options" which were already well under-way. Some influential members of Congress championed this flexibility. The Waiver Program permits payment, as "medical assistance", of all or part of the cost of home and community services (excluding room and board) which are provided, per written plan, to a number of individuals who would otherwise require the "level of care" previously provided in such institutional settings. Please see Attachment A which contains a set of figures comparing the numbers of people, by state, served under the ICF/MR program and those receiving Home and Community Based Services, between 1987 and 1994. In addition to allowing states options in using Medicaid dollars to provide other services, other provisions of the Medicaid Act can also be waived including those relating to statewideness (Section 1902(2)(I), comparability (Section 1902(2)(10)(B) and income and resource rules applicable in the community (Section 1901 (a)(10)(c)(i)(III). With the authority to grant a waiver of comparability, the Secretary of HHS can allow a state to target distinct, specific services for a defined group of individuals, i.e., persons with mental retardation or other developmental disabilities who otherwise require ICF/MR services. These services can be new services otherwise not included in the state plan or enhanced services in amounts in excess of those covered by a state plan. Unless comparability is waived, statutes provide that all recipients would be eligible for a service. A waiver of statewideness permits services to be offered by a state even if not available in every political subdivision of that state. (Currently at least 4 Community Mental Health Boards in Michigan do not utilize the Waiver Program.)

Congress has, since enactment of Title 1915(c), continuously acted to increase the flexibility of, and expand, the Waiver Program. In 1986, amendments to the Title were passed which prevented the establishment of limitations on the costs of the program other than documentation that the program be no more expensive than ICF/MR facilities. In the same year, Congress expanded "habilitation services" to include furnishing educational, prevocational and supported employment services to Waiver participants who had been formerly institutionalized. Expansion to cover persons with developmental disabilities who had been inappropriately placed in nursing homes occurred in 1987 (Section 1915(c)(7)(B)).

No historical survey would be complete without a reference to the Community Supported Living Arrangements (CSLA) enacted by Congress in 1990. This legislation was the end result of an intense effort, primarily led by Senator John Chaffee of Rhode Island, to shift Medicaid dollars from institutions to community programs. Whether one chooses to view CSLA as a significant milestone or as "crumbs" tossed to the defeated forces, it did give us vital experience in supporting people to live in homes of their choosing. Once some people experienced life under CSLA, there was no turning back. Many of the key aspects of the new HAB Waiver came out of the CSLA experiences.

REQUIREMENTS:

In exchange for state participation in the Waiver Program and granting a state Waivers, a state must provide certain assurances. Congress afforded further flexibility to states, however, by allowing them to determine how these assurances would be met.

Assurances must be provided by the state as to the financial accountability of funds for these services and that recipients will have their health and safety protected through the provision of necessary safeguards. (Sec. 1915(c)(2)(A))

Assurances that Home and Community Based Services are only provided to individuals who could otherwise qualify for ICF/MR, hospital or nursing facility services and that they require such services but choose to utilize the Waiver. (Sec. 1915(c)(2)(B)(C))

Assurances are required that the average annual cost of providing home and community based services shall be no higher than institutional costs. (Sec. 1915(c)(2)(D))

A written plan is required to provide services under the Waiver. A very important provision in Michigan's proposed renewal is the requirement for Person Centered Planning. This provision is an example of the kind of flexibility a state has in writing its plan. See Attachment B for the Howell Group's definition of Person

Centered Planning. Waivers are granted under Title 1915(c) for three years for a new request and subsequently require renewal every five years. Michigan has just completed its second renewal request. Michigan's participation began in 1988. Amendments to the state's waiver are possible at any time.

COST COMPARISON:

Nationally, and in Michigan, utilization of the Home and Community Based Waiver has grown steadily. For Michigan, the number of individuals served by the Waiver exceeded those served in ICF/MRs (largely AIS homes) in 1995. This was true nationally, as well. The number of people served in ICF/MRs has only recently begun to shrink across the country and has not decreased appreciably in Michigan in the 1990's.

Costs have increased dramatically in the ICF/MR program since the inception of the Waiver Program despite little or no growth in the number of residents. Expenditures only recently stabilized at about \$9.2 billion/year when the number of residents in those facilities decreased by 7% in FYs 1993 and 1994. Expenditures for FY94 for Waiver participants totaled approximately \$3 billion or less than 1/3 of expenditures in the ICF/MR program although the number of participants were nearly 90% of those in ICF/MRs.

For 1994, in Michigan, ICF/MRs served about 3,200 people at an average cost of \$66,361/person. There were 3,130 Waiver participants served at an average cost of \$27,537/person. Total Medicaid costs were \$68,518/person in an ICF/MR and \$45,126 for a Waiver participant. It is anticipated that costs over the next five years will rise to approximately \$88,899 for an ICF/MR resident, while the total Medicaid cost for a Waiver participant will grow to \$59,198.

DEVELOPMENT OF CURRENT WAIVER RENEWAL

Michigan has utilized much of the greater latitude and flexibility which have been increasingly available under the Waiver. People with disabilities, their friends and advocates and many service providers gave impetus to what they saw as a need for real change in how people with disabilities were served in their communities. With the goals of inclusion and participation in the community and the supports and assistance that would afford people control and choices in their own lives and over their destiny, these groups sought ways to effect such a change.

Initiation and participation in local model projects was a starting point for many. Focus groups which led to the establishment of, and involvement in, Consumer Choice programs was another. Drafting of Michigan's Community Supported Living Arrangements (CSLA) proposal and participation at pilot sites was still one more way in which people either pushed for this "new way" of providing service to people with developmental disabilities or began to see its potential.

One group, inclusive of many of these other groups and individuals, which coalesced these efforts and spearheaded this desire to change the focus and methodologies of the "service system" was the Howell Group. The Howell Group had been meeting once a month, quite informally, for a number of years. Among its "members" were a number of local Arc chapters, some Community Mental Health Board employees, providers of direct services, Department of Mental Health employees, The Autism Society of Michigan, United Cerebral Palsy of Metro Detroit and of Michigan, Michigan Protection and Advocacy Services, Wayne State's Developmental Disabilities Institute, one Center for Independent Living, as well as primary and secondary consumers.

The stated purpose of the Howell Group was to make major differences in Michigan's service delivery system and affording people with disabilities the options and assistance they wanted. The ranks of the Howell Group grew appreciably as the Department of Mental Health demonstrated its willingness to accept the input, to change and even take ownership of this major shift.

The initial thrust of the Howell Group and others, as it relates to the Waiver, was to successfully seek an amendment to Michigan's then current Habilitation Waiver. In 1992, the HAB Waiver was successfully amended to include a supports option. This also made Person Centered Planning an option to "Active Treatment" and personal assistance became a possibility to support people in their own homes.

Unfortunately, this amendment did not bring about the results anticipated. Implementation problems - both in the manner in which the new "supports" were to be billed - and the requirement of a dual system for those not served in this manner or in licensed settings - were both deterrents. Unfamiliarity with these options, a lack of effective training, and resistance to change also meant these options were seldom chosen.

Over the course of the Howell Group's discussions and deliberations, they consistently sought outside input and information from other states, especially as it regarded their experience with the Waiver, but around other "best practices" as well. The Howell Group benefited from consulting with Dr. Colleen Wieck, Jay Klein, Derrick Dufresne, John and Connie (Lyle) O'Brien, and Dick LePore. This not only broadened our perspective significantly, it allowed us to be aware of what was possible elsewhere.

All of these efforts served only to whet the appetite for change. Increasing numbers and expansion of CSLA pilot sites brought new enthusiasm and new champions. The statewide Steering Committee for Michigan's CSLA project lent its weight to the call for change in Michigan's rules and policies governing the Waiver. The realization that CSLA would end as a Medicaid pilot made the Waiver more important as the vehicle by which CSLA participants would continue to receive service and support. However, unless there were major changes, the choice and self-determination people had experienced and enjoyed through the

Pilot would be gone. New enthusiasm was also fueled by the feedback and results of the Howell Group's survey of users and providers of mostly traditional "Waiver Services". There was great dissatisfaction with the status quo and a real desire evidenced to see the system change.

Everyone involved, especially the Howell Group, also felt tremendous pressure to establish a methodology for planning with and supporting individuals to achieve their goals and enhance their participation and contribution which could serve as a blue print, should Medicaid block grants, or a capitation, change Medicaid forever. Consciously, members of the Howell Group sought to spell out the basis for all services to people with developmental disabilities which would be provided by the Department of Mental Health and beyond. They sought and have subsequently been assured by the leadership of the Department that what has been fashioned would, in fact, provide the framework for all services to persons with developmental disabilities in the future.

This led to an effort, with the cooperation and collaboration of the Department of Mental Health to tackle and substantially revise the required 5 year renewal request for Michigan's Waiver due before October 1, 1995. Because of all the previous work, certain tenets were incorporated:

The honoring of each person's preferences and choices, including the presumption of competence and interpreting behavior as communication.

Assuring that Person-Centered Processes were utilized in planning for any individual receiving services through the Waiver and ultimately each individual served.

Doctors and other professionals would serve in consultative roles and their involvement would be only as desired or needed. Regular consumer feedback and a focus on the outcomes an individual wants would form the basis for quality assurance.

Paperwork and documentations would be reduced and held to a minimum.

The person who coordinates supports would play a personal agent role to help an individual achieve the outcomes they wished.

Informal and generic supports would be considered prior to the implementation of supports through the Waiver.

Eligibility would be broadened to include the Federal definition of developmental disability.

External people and anyone unwanted would not intrude in the lives of individuals served through the Waiver.

Many of these assurances had been formalized in a document entitled "Principles for Services to Individuals with Disabilities and Their Families" that was signed by the Directors of the following state departments on July 11, 1994:

Department of Mental Health
Department of Education
Department of Public Health
Department of Social Services
Office of Services to the Aging

(See Attachment C)

Subsequently, Michigan's renewal request was submitted. Michigan was notified on December 15, 1995, that their Waiver Renewal Request had been approved by Health Care Financial Administration, retroactive to October 1, 1995. However, one should consider Michigan's Waiver Renewal a work in progress. We know many things and will see the above tenets adhered to. However, exact implementation, timing and the training necessary are yet to be determined.

The financial request that the Department of Mental health made in the Waiver is strong testimony of its commitment to a new way of serving people. The asked for funding to serve an additional 2,000 people in the initial year of the Waiver. The total amount requested over the five years of the Waiver will allow Michigan to serve nearly 10,000 people in this program by the year 2,000. In approving the Department's estimate of utilization and costs, the federal government committed itself to a total budget for the new waiver of \$565,577,692. The Department is indeed to be commended!

II. FEDERAL POLICY DECISIONS ON MEDICAID

When the 104th Congress began its fall session in 1994, their primary goal was to implement their Contract with America. One of the basic tenets of this Contract was to balance the budget and eliminate the federal deficit by 2002. In order to balance the budget, the Congress has determined that overall federal spending must be reduced by \$894 billion over the next seven years. Unfortunately, most of the programs on the table for overall deficit reduction are those of importance to children and adults with disabilities. These include critical entitlements such as Medicaid and domestic discretionary programs like education, housing, jobs, etc. As Congressional leaders work to balance the budget, three major areas of federal spending are not on the table for reduction. These three items are **defense spending**, **social security** and **interest on the debt**. These three areas alone make up 52% of current federal spending. This means that

Congress is trying to balance the budget with only 48% of the available funds. Therefore, the urgency on the part of Congress to reduce spending on Medicaid.

According to Congressional Budget Office (CBO) figures, in 1995 almost 37 million low income individuals qualify for Medicaid, including:

18.5 million poor children (almost 1/2 of the total Medicaid population) 7.8 million low income women
6.0 million low income individuals with disabilities - and 4.3 million low income elderly

At the time of this writing there appear to be two primary policy alternatives. The first is the Bill enacted by Congress, the "Medicaid Transformation Act of 1995." This bill would convert Medicaid into a block grant to states called Medigraunt. Giving Medicaid to the states in the form of a block grant would eliminate the federal regulations which currently guarantee coverage for certain vulnerable groups, and would appropriate a fixed amount of money to the states each year, regardless of the number of needy people - or the cost of their care. This fixed amount would increase slightly each year, but not at the rate of growth previously experienced. Congress believes that allowing the states more control over medicaid rules, regulations, services, etc. will enable them to absorb these reductions in spending with no reduction in services.

As he vetoed Congress's Bill, President Clinton offered a second alternative. It appears that the President favors the following provisions:

- Agreement with Congress on the need for flexibility to address the problem of costly over-regulation.
- Placing a cap on growth, rather than eliminating the removing of all federal requirements, as Congress has proposed through the mechanism of undesignated block grants.
 - A lower percentage of cuts in Medicaid spending than Congress (a savings of \$54 billion over seven years versus \$163 billion).
 - Maintaining federal eligibility requirements for children and adults with disabilities, rather than having each state make that determination as Congress proposed.

What does all of this mean to us? All the work that has been done on the HAB Waiver becomes of even more importance. The Department of Mental Health has made a commitment to administer Michigan's Medicaid program based on the principles and services outlined in this waiver. If Medicaid becomes a block grant, there will be no "waivers". However, since each state would still be required to submit a plan - our HAB waiver could become the basis of our state plan. Additionally, in the Principles for Services to Individuals with Disabilities and Their Families it is stated that it will be the policy of each of the participating state departments to administer their services by "Recognizing the value, worth,

capacities and productivity of individuals with disabilities, the State of Michigan will array its services, supports, coverage and entitlements offered through public services so that by design and implementation, they will foster, preserve and enable each person to achieve maximum potential and participation in their families, relationships, communities and Michigan's work force." (See Attachment C) They spelled out how the 17 service principles would guide decision making by the directors in the conduct of public/private partnerships which will focus on common outcomes of services provided to people with disabilities and their families.

It is imperative that we, consumers, advocates, family members, professionals and friends, hold our state departments to these principles and work as partners with them in the development of such strategies as needed to ensure implementation.

III. NEXT STEPS

As we enter this new era of delivering services to Michigan's citizens with developmental disabilities, we can do so with optimism and hope because we have the opportunity to create a new service system that will be far more responsive to consumer and family needs than the old. We can create a system that will welcome input from all members of the community, value professionals and caregivers, and provide services and supports based on the desires and needs of the individual.

We suggest the following strategies:

1. Incorporate the key provisions contained in the HAB Waiver and the newly revised Mental Health Code into a revision of the Mental Health Administrative Rules and Department Guidelines.

This re-drafting should occur in an inclusive process involving advocates, family members and consumers, Community Mental Health staff as well as representatives of the Department of Mental Health.

2. The major state departments must incorporate the provisions of their July 1994 Declaration of principles into guidelines and the HAB Waiver for the distribution of all Medicaid services.
3. Vigorous advocacy efforts should be initiated at the local level to gain the broadest possible support to implement these changes. (See Attachment D for information on the Kalamazoo Coalition for Excellence in Mental Health.)
4. Advocacy efforts directed toward the 1996-1997 Department of Mental Health Budget should affirm the principles of the new Waiver. (See Attachment D, also)

However, it is necessary to become active participants in the process. In addition to the efforts of the Howell Group, which will remain great, some communities are developing coalitions. One such group in Kalamazoo County, known as the Coalition for Excellence in Mental Health, includes Community Advocates for Persons with Developmental Disabilities (the local Arc affiliate), the Alliance for the Mentally 111, the Michigan Association for Children with Emotional Disorders, the Consumers Council, and Community Mental Health. They have determined that advocacy on mental health issues is a year round job; that they must work at all levels of decision making and do it with others; that they must have a vision and set of principles by which decisions are made; that it is necessary to have as much information as possible, especially good stories and illustrations; that they need to integrate the policy issues; and that they need to make specific proposals.

The Coalition has developed an overall theme: Complete the job of building community-based mental health services and consider funding sources for the future. They have also established the following organizing principles: (1) Respect for consumer choice; (2) Inclusion of family in decision-making; (3) Maximum flexibility in planning and delivering funding services; and (4) Emphasis on brokering of funding from other services.

These principles are consistent with those established by the heads of Michigan's social services departments, the HAB Waiver, the Howell Group, etc. If we are to be truly effective in the future, it will be necessary for all of us to become involved in coalitions, partnerships, etc.

IV. CONCLUSION

It is our goal to use this document as an informational, as well as advocacy, tool. It cannot be called the definitive word on the subject of the Waiver or Medicaid, since change is a constant. At this point, we do know that Michigan's HAB Waiver renewal will be implemented in the new year. We do not know what is going to happen with the total Medicaid program. What we do know is that effective advocacy for change occurs only through ongoing efforts of advocacy organizations and groups such as the Howell Group. These efforts will continue.

Dohn Hoyle, President

Washtenaw Association for Community Advocacy

December 1995

TRENDS AND MILESTONES

Edited by K. Charlie Lakin, David Braddock, and Gary Smith

Milestone Reached in ICF/MR Utilization

The Medicaid Intermediate Care Facility for the Mentally Retarded (ICF/MR) program was created in 1971 to improve quality and provide federal cost-sharing for institutional services for individuals with mental retardation. Beginning in the mid-1970s, ICF/MR services were increasingly provided in community facilities of 4 or more residents. ICF/MR participation requires adherence to uniform institutional and program standards. The Medicaid Home and Community Based Services (HCBS) program was created in 1981 to provide alternative community services to people who without these services would be at risk of institutional placement. States have steadily adopted this alternative to ICF/MR. Despite rapid growth of HCBS, since 1982 the number of ICF/MR residents remained remarkable stable, and ICF/MR expenditures steadily increased. Fiscal years (FYs) 1993 and 1994 brought the first change in this trend as total ICF/MR residents decreased by 7%, and ICF/MR billings stabilized for the first time, actually decreasing slightly (at \$9.2 billion both years). In contrast, between FYs 1993 and 1994, HCBS recipients increased from 86,604 to 122,075 and expenditures increased from \$2.2 to 3.0 billion. Figure 1 shows recipient and expenditure patterns from 1982 to 1994. Table 1 shows 1994 ICF/MR and HCBS recipients and changes from 1989 to 1994.—KCL

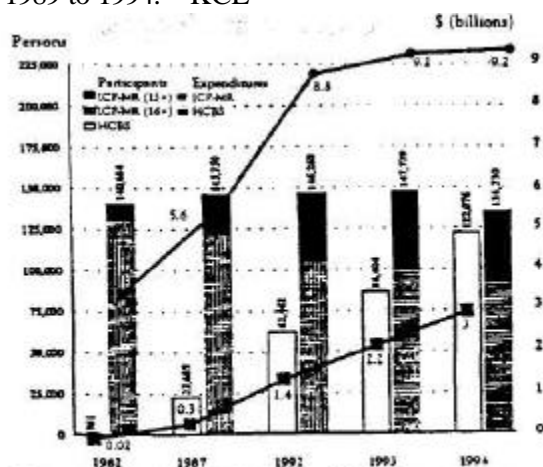


Figure 1. Medicaid ICF/MR and HCBS recipients and expenditures, 1982-1994.

Table 1
Total Number and Changes Between 1989 and 1994 in ICF/MR and HCBS Participants

State	ICF/MR		HCBS	
	No. residents	% change	No. recipients	% change
AL	1,145	-13.7	2,900	+58.5
AK	78	-19.6	32	(+32)
AZ	339	+391.3	6,773	(+6,773)
AR	1,743	+21.0	429	(+429)
CA	12,781	+16.4	13,266	+295.4
CO	420	-62.3	2,684	+59.9
CT	1,276	-45.4	2,361	+109.5
DE	356	-19.5	310	+210.0
DC	722	+12.6	0	(+0)
FL	3,407	+7.1	6,430	+153.0
GA	1,897	-2.4	556	+2,124.0
HI	142	-42.3	513	+632.9
ID	527	+1.3	333	+23.3
IL	10,979	+1.1	4,590	+575.0
IN	2,329	-57.7	529	(+529)
IA	1,818	0.0	879	6,178.6
KS	1,767	-9.6	1,339	+326.4
KY	1,133	-3.9	887	+21.8
LA	6,029	-0.6	1,543	(+1,543)
ME	542	-21.9	742	+63.8
MD	822	-40.2	2,787	+242.8
MA	2,119	-23.7	5,130	+324.0
MI	3,366	+13.8	3,367	+160.6
MN	4,838	-16.1	4,385	+112.0
MS	2,077	+30.8	0	(+0)
MO	1,709	-8.0	3,057	+804.4
MT	171	-31.6	546	+99.3
NE	694	-8.2	1,257	+132.8
NV	205	+10.8	172	+26.5
NH	73	-53.8	1,303	+71.0
NJ	3,975	+4.0	4,729	+49.2
NM	585	-22.1	402	+197.8
NY	16,083	-9.5	18,877	(+18,877)
NC	4,732	+49.1	1,318	+138.3
ND	551	-25.8	1,509	+42.0
OH	7,821	-1.9	2,159	+899.6
OK	2,268	-25.9	1,193	+238.6
OR	417	-58.9	918	+75.4
PA	6,950	-1.9	2,373	+122.9
RI	353	-63.1	884	+196.9
SC	3,111	-3.7	966	(+966)
SD	502	-15.1	321	+47.0
TN	2,350	+8.0	490	+103.4
TX	13,742	+13.7	1,147	+275.1
UT	924	-8.1	466	+41.5
VT	42	-82.2	722	+157.9
VA	2,466	-13.0	715	(+715)
WA	1,302	+45.9	3,068	+183.0
WV	640*	-16.0	803	+258.5
WI	3,749	-25.2	2,315	+153.6
WY	156	(+156)	565	(+565)
U.S.	136,730	-7.1	122,075	+248.0

Note. Parentheses indicate increased participants from a 1989 base of zero.

*1993 data.

PERSON CENTERED PLANNING

A person centered plan assists individuals to create a personalized image of a desirable future. The development of a plan suggests a process that can organize and guide community change in alliance with people with disabilities thus building the bridge from both sides.

Essential to all person centered plans are the following characteristics:

Person directed - The plan for the person is that person's vision of what he or she would like to be and do. The plan is not static, but rather it changes as new opportunities and obstacles arise.

Capacity Building - Planning focuses on the person's gifts, talents and skills rather than deficits. It builds upon the individual's capacities and affords opportunities which will reasonably encourage individuals to engage in activities that promote a sense of belonging in the community.

Person Centered - The focus is continually on the person for whom the plan is being developed, and not on plugging the person into available slots in a program. The individual's choices and preference must be honored.

Network Building - The process brings together people who care about the person, and are committed to helping the person articulate their vision of a desirable future. They learn together and invent new courses of action to make the vision a reality.

Outcome Based - The plan focuses on increasing any or all of the following experiences which are valued by the individual:

- Growing in relationships or having friends.
- Contributing or performing functional/meaningful activities.
- Sharing ordinary places or being part of their own community.
- Gaining respect or having a valued role which expresses their gifts and talents.
- Making choices that are meaningful and expresses individual identity.

Community Accountability - The plan will assure adequate supports when there are issues of health and safety, while respecting and according their full dignity as a **fully** participating member of the community.

Adopted by the Howell Group of Michigan, October 1994

PRINCIPLES FOR SERVICES TO INDIVIDUALS WITH DISABILITIES AND THEIR FAMILIES

INTRODUCTION

This document contains a statement of philosophy and a set of principles that will serve to guide decision making by directors of state human services agencies in the conduct of public/private partnerships which will focus on common outcomes of services provided to people with disabilities and their families.

As co-signators to this document, the efforts and resources of the respective departments are pledged to the establishment and advancement of the policy, principles and philosophy contained herein; to promote the implementation of services which adhere to these principles; to work with other systems as necessary to support the efforts of human services agencies; and to recommend supportive legislation and or policy where needed. Further, the service systems governed by the state departments identified herein desire that all program policies and principles and implementation strategies are developed in partnership with individuals served and their families.

POLICY

Recognizing the value, worth, capacities and productivity of individuals with disabilities, the State of Michigan will array its services, supports, coverage and entitlements offered through public services so that by design and implementation, they will foster, preserve, and enable each person to achieve maximum potential and participation in their families, relationships, communities and Michigan's work force.

SERVICE PRINCIPLES

PREVENTION: Programs, policies, services and supports shall be developed, designed and delivered in a manner that reduces the incidence, -severity and impact of primary, secondary and related conditions associated with Impairment and/or loss of functioning.

FOSTERING RELATIONSHIPS: Policy, programs, services and supports shall emphasize resources which contribute to each person's participation and sense of value as a member of their family, community and state.

CULTURAL SENSITIVITY: Programs, policies, supports and interventions shall recognize, value and respect the culture, traditions, spirituality and religious preferences of each Individual and their family. Communications regarding programs and services shall be multilingual, multimedia and conveyed in language easily understood by the consumer.

EMPOWERMENT: Programs, policies and supports are to be designed so as to be guided by the informed choice, preferences, vision and values of the individual(s) served.

- **SELF RELIANCE:** Programs, policies and supports are to be designed and delivered in a manner which promotes the self reliance and personal dignity of the person(s) served. Assistive devices and technological supports shall be utilized to promote self reliance.

TRANSITIONING TO INDEPENDENCE: Individuals with disabilities and their families are to be assisted and supported in ways which help them to maintain or acquire the economic means to have a reasonable standard of living; building on a foundation of adequate food, clothing, housing, transportation and wellness.

BUILDING CAPACITIES: Services/plans are to capitalize upon and increase the strengths and capacities of the individual(s), and families served rather than focus on limitations.

FULL PARTICIPATION: Individuals with disabilities and their families shall be able to expect the service delivery system to focus its attention on developing, promoting and supporting integrated, community-based service system.

HEALTH AND SAFETY: The community systems shall establish, support and utilize generic services which help to ensure an individual's health and well-being. Community standards for health and safety shall be applied.

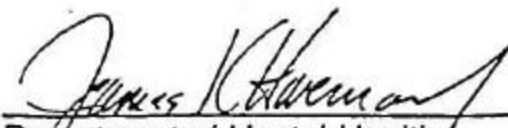
ACCESS TO SERVICES: -Recognizing the importance of the individual's satisfaction with life in the community, the service system has an inherent obligation to arrive at a basic threshold of services/supports availability. Services must be meaningful and responsive to the individual served. Assistance and support/outreach to enable individuals and their families to access services must be considered.

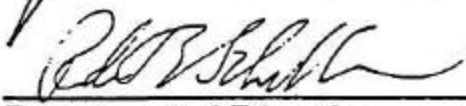
EFFECTIVENESS: Creativity and flexibility in service delivery are to be encouraged within the parameters of.

demonstrated need;
customer satisfaction;
persuasive indicators of improved quality, outcomes, efficiency
and effectiveness;
economic rationality.

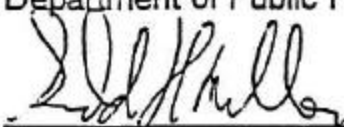
- **STANDARDS AND ACCOUNTABILITY:** Standards will be established and services will be evaluated according to individualized outcome expectations. Services shall respond to assessment(s) of need, involve both service community and client, and incorporate customer satisfaction with services received.
- **SEAMLESS SERVICES:** Programs, policies, services and supports shall, in their design and implementation, reflect organizational and delivery approaches aimed at making human services more comprehensive, accessible and responsive to the multiple, holistic needs of the persons and families served. Whenever possible, systems and agencies should strive to accomplish reciprocity with applications, assessments, releases and planning documents.
- **SYSTEM FLEXIBILITY/SERVICE INTEGRATION:** Service systems must be designed to fit the needs and circumstances of the individuals and the communities wherein they are receiving service in order to maximize desired outcomes for individuals with disabilities. Constituent and interagency collaboration, incorporating and affixing accountability for multiple services are both encouraged and supported.
- **QUALIFICATIONS OF SERVICE PROVIDERS:** The state must assure qualified providers of services.
- **DUE PROCESS:** Recipients of public services must have access to due process in the pursuit of a complaint or grievance.
- **LEAST RESTRICTIVE ENVIRONMENT:** -Services will-be-offered in the environment that affords the greatest degree of freedom and self-determination. Reasonable accommodations shall be extended to enable the full participation of the service recipient The physical environment for public services shall be physically accessible, afford confidentiality and promote the dignity and worth of the service recipient A service environment placing restriction or disruption upon the service recipient shall be a matter of last resort have documented evidence of previous unsuccessful efforts in a less restrictive environment, or be a matter of crisis management and contain a plan for return to a lessor or non-restrictive environment

Signed at Lansing, Michigan by:

Date: July 11, 1994 By: 
Department of Mental Health

Date: July 11, 1994 By: 
Department of Education

Date: July 11, 1994 By: 
Department of Public Health

Date: July 11, 1994 By: 
Department of Social Services

Date: July 11, 1994 By: 
Office of Services to the Aging

COALITION FOR EXCELLENCE IN
MENTAL HEALTH

DMH Budget
"Rules" for Organizing

- I. IT'S A YEAR ROUND JOB *i*
- II. WORK AT ALL LEVELS OF DECISION-MAKING
- III. DO IT WITH OTHERS
- IV. START & END WITH VISION & PRINCIPLE
- V. GATHER AS MUCH DATA AS POSSIBLE
- VI. STORIES & ILLUSTRATIONS HELP
- VII. MAKE SPECIFIC PROPOSALS
- VIII. INTEGRATE THE POLICY ISSUES

Attachment D

SAMPLE OF LOCAL ADVOCACY

COMMUNITY COALITION
FOR
EXCELLENCE
IN MENTAL
HEALTH

(This material is included as an example only. Please note the DRAFT stamp. The Coalition has not finalized its position on the 1996-1997 DMH Budget.)

ADVOCACY POSITION ON
1996-1997 DMH Budget

Overall Theme: Complete the job of
building community-based mental health
services and consider funding sources for the future.

Alliance for the Mentally 111 - SHARE Community
Advocates for Persons with Developmental Disabilities
Consumers Council
Mental Health Executive Director's Council Michigan
Association for Children with Emotional Disorders

COMMUNITY COALITION FOR EXCELLENCE IN
MENTAL HEALTH

ADVOCACY POSITION ON 1996-1997
DMH BUDGET

Budget Priorities

- A. Continue last year's increase of 5% for residential services and extend the 5% increase for all CMH services in the FY 96-97 DMH budget.
- B. Assure CMH Boards are the provider of choice for all Medicaid-funded CMH services. Consider capitated mechanisms that assure any resulting savings go to increase service capacity.
- C. Assure person-centered planning and consumer satisfaction are the base for DMH requirements and for CMH Medicaid requirement, whatever form Medicaid takes in the future.
- D. When Medicaid comes to the state in the form of a block grant, require a maintenance of effort so that the proportion of Medicaid funding CMH service is maintained.
- E. With the Medicaid block grant, reduce over-regulation and over-professionalism that currently exists. Have one set of requirements, preferably just CARF, JCAHO, or COA.

We wish to thank the following individuals for their financial contributions to this effort.

Contributors to Push for Community Project

<u>Statewide Organizations</u>	\$1,500
Michigan Conference of Executives of Arc's	
Michigan Protection & Advocacy	

<u>Local Organizations</u>	\$4,500
Community Advocates	
The Arc Northwest Wayne County	
Kalamazoo RICC	
The Arc Van Buren	
The Arc St. Clair County	
Wayne Community Living Services Inc	
Berrien RICC	
MRC Industries (Kalamazoo)	
Residential Opportunities Inc (Kalamazoo)	
The Arc of Midland	
The Arc Allegan County	
The Allegan County RICC	

<u>Individual Contributions</u>		\$1,395
Jan Gormely	Betti Gruits George &	
Dohn Hoyle	Gail Martin Alice	
Nancy Rosenau	Wall Andy Sugar	
James Fortushniak	Sylvia Kloc Elizabeth	
Karen & Mark Longanecker	Augustins Donal D	
Barbara LeRoy	Hammond Ann	
John & Sally Lindsay	Carrellas William	
Karen Wolf-Branigin	Finzel Sandra	
Edward & Myrna Bartlett	McClennen	
Marlys Waller		

TOTAL	\$7,395
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